

November 20, 2002

VHA NATIONAL DUAL CARE POLICY

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes the VHA National Dual Care Policy which delineates a system-wide approach to the coordination and provision of medical care that optimizes the quality, appropriateness and efficacy of care, medications, prosthetics and supplies provided to eligible veterans who are seen by both Department of Veterans Affairs (VA) and community providers. *NOTE: This does not address the prescription of sensori-neural devices.*

2. BACKGROUND

a. Dual care is common throughout the VHA system. Although ideally each veteran should have a single primary care provider who oversees all aspects of care, some patients choose to see non-VA health care providers as well as VA providers. The majority of such patients appear to be primarily interested in the VA pharmacy benefit. As the cost of pharmaceuticals increases and Health Maintenance Organizations (HMOs) and other third party payers increase co-pays or eliminate their pharmacy benefits altogether, the number of veterans seeking medications from VA is increasing and severely stretching VA resources. Of significant concern is the increasing wait time for appointments, and our ability to safely accommodate veterans with no other source of health care in a timely manner. This policy therefore is intended to provide guidance as to how to maximize the effectiveness of VA and ensure consistent, appropriate and safe care for all veterans using VA medical services.

b. Veterans who are considered to be receiving dual care are, for the most part, those who receive the major portion of their health care in non-VA settings, but who use VA primarily for pharmacy benefits. A likely smaller percentage of “dual-care veterans” get their care in the community and use VA only for specialized services.

c. VHA facilities and their associated primary care providers should encourage veterans to receive all of their primary care through VA.

d. Since VA believes it is essential that veterans have access to preventive care such as cancer screening, flu shots, etc., all providers or their associated primary care team members should assess and document that preventive services have been given. *NOTE: Those services need not be repeated in VA as long as the record includes the dates and results of such testing.*

3. POLICY: It is VHA policy to provide care to veterans concomitantly receiving care using the following rules: veterans seeking care, medications or supplies from VA must be enrolled in, and have at least one visit with a primary care provider; if the veteran wishes to receive ongoing medication or services for primary care health needs, the veteran must be followed and managed by a VA primary care clinician and/or team, even if some of the care is provided in the community; specialty services provided for dually cared for veterans will be provided according to the local facility or the Veterans Integrated Services Network (VISN) policy, once the patient has been enrolled in primary care. In any event, for both primary and specialty care, the VA clinical record must document and support the need for all medications, testing and treatment recommended or provided by VA.

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4. ACTION

a. VA Provider (Community)

(1) The VA provider assumes medical and legal responsibility for and has the final authority for decisions regarding any medications and supplies the VA provider prescribes. As such, the VA provider is under no obligation to order medications or diagnostic testing for any condition for which the veteran does not allow the VA provider to adequately manage.

(2) The clinician writing for medication must be competent to manage the care of the patient for which the medication is being prescribed. Under no circumstances will a VA clinician be permitted to simply re-write prescriptions from an outside provider.

(3) In instances where highly specialized medication is being requested by the veteran, the patient must be seen by a VA provider competent in that specialty, or the prescribing clinician must be in direct verbal or written contact, or acting on recommendations of a VA provider competent in that specialty. Such communication must be documented in the clinical record.

(4) VA providers are under no obligation to follow a treatment or medication plan recommended by community physicians if they disagree with that plan or if that plan conflicts with national or local policies related to prescription of non-formulary or restricted medications. The VA provider needs to communicate the rationale for medication changes or refusal of medications to the veteran, and document this communication in the medical record.

(5) Patients who receive controlled substances on a chronic basis require close monitoring by one designated provider. Dual care of these patients needs to be avoided, unless both providers collaboratively determine that it is in the best interest of the patient. Provision of controlled substances for these patients must be closely monitored and coordinated between providers.

(6) **Monitoring of High-Risk Medications**

(a) Lab tests and other necessary monitoring for high-risk medications such as Warfarin, anti-arrhythmics, lithium, chemotherapy, etc., and those medications for which the patient dose has not been stabilized, need, ideally, to be done in VA.

(b) Under circumstances related to geographic or other hardship requiring the patient to have tests done on the outside, the veteran must be required to provide written proof of those results, and the VA provider writing the prescription must document such results in the progress note, prior to prescribing.

(7) **Provision of Emergency Supplies of Medication Written by an Outside Clinician.** VA is under no obligation to provide emergency supplies of medication written by an outside provider, unless it is believed that failure to do so would result in short-term serious morbidity or mortality.

b. **VA Clinician Responsibilities.** Any VA physician being asked to treat a veteran may, and in fact has the ethical and professional responsibility to, refuse to continue treatment prescribed

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by another provider (VA or community provider) if the physician believes the treatment is inappropriate. **NOTE:** *In such cases, the veteran may use the VA clinical appeals process.*

c. **Patient Responsibilities.** The veteran is responsible for:

(1) Informing the veteran's outside provider(s) of care being provided in VA.

(2) Providing the VA provider with the name and address of all outside providers the patient is seeing.

(3) Obtaining all necessary records and documentation from an outside provider. **NOTE:** *Costs relating to duplication of private sector records are the responsibility of the veteran.*

d. **VA Payment for Care or Medications Recommended by non-VA Providers.** Except in the instance of fee-basis care, and certain provisions in the Millennium Bill for emergency care, VA has no responsibility to pay for testing, medications, or treatment recommended by a non-VA provider.

5. REFERENCE

a. Public Law 104-262 VA Healthcare Eligibility Rules.

b. General Counsel Opinion, Furnishing Drugs and Medicines Prescribed by Private Physicians, U.S. Department of Veterans Affairs Opinion O.C. 11-83: October 11, 1983; (reissued as Vet. Aff. Op. Gen. Counsel Prec. 41-91, 1991)

6. FOLLOW-UP RESPONSIBILITY: The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this directive.

7. RESCISSIONS: None. This VHA Directive expires July 31, 2007.

Robert H. Roswell, M.D.
Under Secretary for Health

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